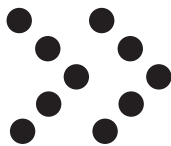


Section 5

Conclusions and Recommendations from the Literature Review updating the Evidence on Physical Activity: Towards a National Physical Activity Strategy for Australia



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❖ SECTION 5

CONCLUSIONS AND RECOMMENDATIONS FROM THE LITERATURE REVIEW UPDATING THE EVIDENCE ON PHYSICAL ACTIVITY: TOWARDS A NATIONAL PHYSICAL ACTIVITY STRATEGY FOR AUSTRALIA

This section provides a summary of the findings of the review of literature on physical activity undertaken as a consultancy commissioned by SIGPAH as part of Phase I of a process towards developing a new National Physical Activity Strategy in Australia. The work was undertaken between September and December 2003 by a national consortium of researchers with expertise in physical activity and health. Input from SIGPAH and national and international experts was also sought at the National Physical Activity Conference held in Fremantle, Western Australian (November 2003).

The consultation involved updating the epidemiological and intervention focused literature on physical activity with a specific focus on the past three years (2000–2003) using the documentation and structure of *Getting Australia Active* as a framework (Bauman et al. 2002). This update also added two new sections: a review of existing health strategies and policy documents in Australia, especially those related to public health and physical activity; and an international review of policy on physical activity in other countries.

This section provides a brief summary of the four key areas of the full report, followed by a summary of the critical issues and influencing factors pertinent to the development of a new National Physical Activity Strategy in Australia.¹⁴

¹⁴ Section 5 has been designed to serve as a stand alone document which might contribute, with little or no editing, to the Phase II consultation process envisaged for the development of the National Physical Activity Strategy in Australia.

5.1 Summary of the Update Review of Epidemiological Evidence 2000–2003

The promotion of physical activity is developing as an important part of health sector investment, but constant referral to the evidence base is needed to justify this position. This review updated the epidemiological evidence that physical activity confers a positive benefit on health and reduces risks of ill health, using research studies in the peer reviewed scientific literature published between 2000–2003. The review focused on evidence for health gain among adults who are active, compared with those who are inactive. Areas covered included cardiovascular disease, diabetes, stroke, mental health, prevention of falls and obesity. Although the focus was only adults, it should be noted, that at the time of writing the Australian Government was in the process of convening a special workshop to develop Physical Activity Recommendations for Children and Youth (Trost 2003). Association between physical activity and cardiovascular disease has been observed and replicated over five decades of research, and shows a graded relationship, with the maximal risk reduction observed among the inactive who move to becoming at least moderately active. Since 2000, several papers have added to our understanding of this relationship, and strengthened the evidence that moderate and brisk intensity walking reduce the risk of cardiovascular disease; in two studies the risk reduction of brisk walking was at least as great as for vigorous activity. The evidence base for women, older adults and special populations has strengthened, with consistent and very similar evidence to that provided by previous studies, that moderate intensity activity on most days provides the greatest risk reduction.

The prevention of diabetes in populations is an important public health concept, given its increase in incidence and an increase in the at-risk aging population in developed countries. Early cross sectional epidemiological research explored the relationship between physical activity and diabetes and showed high rates of diabetes in sedentary population, especially of indigenous and Pacific Island populations. More recent evidence comes from population-based observational cohort studies and in the last few years, even stronger evidence

has become available from randomised controlled trials, which have explored the concept of diabetes prevention. There has also been an increase in work around high-risk populations, particularly those with impaired glucose tolerance. The implications of this work are substantial; there is now evidence that diabetes can be prevented in those at high risk using lifestyle modification including increased levels of physical activity. One caveat is that these interventions are very expensive and intensive. The Diabetes Prevention Project (DPP) trial cost around \$3,000 per participant in the intensive lifestyle intervention. This represents a substantial cost and the detailed program may be difficult for whole populations to participate in and adhere to in the long term.

Cancer prevention studies have proliferated during this period, but the certainty of the evidence base is balanced by studies that do and don't show protective effects of physical activity. The best evidence remains for colon cancer, with better evidence accumulating for breast cancer prevention (especially among postmenopausal women). Evidence for physical activity benefits on other cancers remain mixed.

Other areas, such as mental health, have attracted less research. Four review papers have described the mental health benefits of being active, but all attest to the methodological limitations of the research conducted to date, and the consequently limited inferences possible in this area. Although widely thought to be beneficial to different aspects of mental health, the evidence base for the benefits of physical activity remains limited in terms of the quality of evidence. Similarly, no major new evidence in the area of falls prevention has been published during this period, although that which previously existed is quite compelling, and risks of falls in the elderly are consistently reduced among those exposed to balance training, muscle strengthening and physical activity interventions.

In summary, this review has further strengthened the epidemiological evidence base for physical activity and health, with the most exciting new information in the diabetes prevention realm where diabetes incidence can be substantially reduced by increased physical activity and weight loss among populations at high risk.

5.2 Summary of the Update on the Effectiveness of Interventions to Increase Physical Activity – What Works?

For the purpose of the Phase I consultation, 17 Australian experts¹⁵ in physical activity research were engaged to review physical activity intervention studies which targeted specific population groups, specific behavioural settings, used mediated approaches or addressed the physical environment. The evidence base for each of these areas varies in both quality and quantity.

Each review identified the published literature during the period 2000–2003 using standard search techniques. Literature published prior to 2000 was included in the sections on worksites and the environment, due to weaknesses in the coverage of these areas in *Getting Australia Active* (Bauman et al. 2002). Although the environmental area is now a major focus of research efforts, much of the published work to date has focused on assessing the direction and magnitude of associations between features of the physical environment and levels of physical activity. It is still early days for intervention research in this field.

The methods and findings of the review of intervention research, along with detailed summary tables, are presented in Appendix 1; a longer summary is also provided in Section 2. A brief summary of the major findings for each population and setting is provided below.

Populations

Most studies of interventions aimed at children and adolescents (in 'out-of-school' settings) were conducted in the United States, either as after school, summer camp or family based interventions. Comprehensive school and family programs showed most promise, but overall the results were mixed. There has been considerable interest in studies

¹⁵ Kylie Ball, Wendy Brown, Liz Cyarto, David Dunstan, Billie Giles-Corti, Andrea Lange, Gavin McCormack, Yvette Miller, Gary Moorhead, Alison Marshall, Neville Owen, Terri Pikora, Jo Salmon, Ben Smith, Tya Shannon-Smith, Trevor Shilton, and Anna Timperio

aimed at reducing time spent watching TV and individual studies have reported positive results. However, as was the case for a recent review of these interventions by the US Task Force on Preventive Community Services, the Australian reviewers also found the evidence of effectiveness to be inconclusive (Kahn 2002).

Comparatively little research has been conducted with interventions aimed at young adults (18–30 years) and the results from available studies are mixed. As young adulthood is a time of transition and significant life events (such as getting married and having children) and these are associated with significant declines in physical activity, it was concluded that more work is still required with this population group (Ball 2004).

More work has been undertaken with older people than with younger adults, with a focus on both general levels of physical activity and on the more specific forms of resistance and strength training (Moorhead 2004). Most of the intervention studies have involved either individual advice or group settings such as gymnasias or walking groups, and those interventions with higher levels of contact, complemented by multiple reinforcements of the physical activity message were most successful. There were few new studies investigating interventions with the very old and frail elderly. The review concluded that more work was required with older people in communities that do not have access to specialised 'exercise' facilities.

There was very little published evaluation of interventions with Aboriginal and Torres Strait Islander peoples although there appears to have been an increase in the number and diversity of programs in ATSI communities (Shilton 2004). It was concluded that there is a need for much more effort in this area, in relation to both measurement and interventions, in urban, as well as in rural and remote, indigenous peoples.

The review of physical activity interventions for the 'special' population groups of people with obesity and type 2 diabetes found limited evidence of success from health education and behaviour modification strategies in clinical settings or with selected families or individuals. Combined lifestyle (diet and physical activity) strategies with continued

professional contact were found to be most successful in the short term, for example DPP Trial, but less resource intensive interventions are still required for more widespread dissemination and improved sustainability.

Settings

Schools are frequently identified as an important setting for health promotion. The review found eight studies published since 1999, but only two of these reported a significant increase in physical activity (Salmon 2004). The most effective interventions included changes to the school's physical or policy environments, in addition to curriculum change. There is considerable interest in the development of transport programs aimed at increasing walking and cycling to school. However, only two published studies of strategies to increase active transport to/from school were found. Only one of these showed significant improvements in public but not private schools (Pikora 2003).

Primary health care remains an important setting for the promotion of physical activity and the review of recent publications confirmed that brief interventions involving verbal advice and written materials (eg pamphlets booklet or 'prescription') can produce short-term changes in physical activity (Smith 2004). Studies which involved partnerships between GPs and other health professionals and in which patients received counselling outside the routine contact time with the GP, appeared to show more consistent improvements in PA (Smith 2004).

The workplace is frequently cited as having considerable potential in terms of the health, productivity, and quality of life of the workforce. This review identified 32 intervention studies published since 1998 with most involving health checks, education programs, motivational prompts, exercise programs or incentive based programs. The more successful interventions adopted a more comprehensive approach, including changes in the organisational structure and culture of the workplace, as well as individual programs (Marshall 2004). One new study which promoted active commuting reported success in changing levels of walking but not cycling (Pikora 2004). The review concluded that, while the workplace has

considerable potential for physical activity promotion, more well-designed and evaluated studies are required.

Mediated Approaches

Print and electronic media have frequently been used to promote physical activity, either alone or in combination with other strategies. The review of recent work in this field found that mass media can be effective in raising awareness but that changes in behaviour were rarely reported (Marshall and Owen 2003). Interventions using tailored print materials or telephone interventions have shown some success in changing physical activity behaviour in the short term. It was concluded that better results might be obtained when more than one 'mediated' approach is used, or when media are used as part of a coordinated 'whole community' intervention.

Environment

The influences of the physical and social environment and of policy change have received increased attention in the last few years. Much of the early research aimed to establish new measurement methods and identify the relative importance of many possible environmental elements (Pikora et al. 2003). While this review of recent work found 41 observational studies, only two intervention studies were located (McCormack and Giles Corti 2004). As was the case in the US review (see Table 5.1) it was concluded that simple point of choice interventions aimed at stair use can be effective in changing physical activity behaviour.

Discussion

Although the aim of this review was to 'update' the evidence by focusing only on recently published intervention research, it is interesting to note that the findings concur in general with the recommendations of the recent US review of physical activity interventions (Kahn et al. 2002). In this ongoing US work, established under the guidance of the Task Force on Community Preventive Services, interventions were grouped into three strategy areas: informational approaches;

behavioural and social approaches; and environment and policy approaches. Ongoing work is focusing on urban form (design), land use planning and changes to transportation.

Current findings from this work are summarised in Table 5.1, and show that school based physical education, community wide campaigns and 'improved access' combined with information, are the three most strongly recommended approaches to increasing physical activity. While our Australian update found two new studies to add to the evidence of effectiveness of school-based interventions, the reviewers concluded that *combined* in and out of school approaches might be the most effective way forward in promoting physical activity to children and adolescents.

Our review also found some new evidence of the effectiveness of whole community interventions, such as the 'Wheeling Walks' project which combined mass media and other locally based strategies. To some extent, whole community interventions can also help to provide social support for physical activity within communities, which was one the strategies also 'recommended' by the US report. In relation to the other two strategies 'recommended' by the US Preventive Services report, our review found substantial new evidence on the effectiveness of individually adapted health behaviour change programs, especially for older people and in the primary care setting. It must be reiterated however, that we need to design more innovative ways of delivering these programs than the traditional face-to-face mode that underpinned the successful diabetes prevention interventions.

Both the US review and the current update found evidence of success with point of decision prompts to use stairs. It should be remembered, however, that a large proportion of the Australian population does not have access to stairs, so that the impact of widespread dissemination of this strategy would be largely limited to able-bodied people who live and work in environments with stairs and who are not constrained by the presence of young children in strollers and prams.

Best Buys?

As the current review was essentially an update of evidence published in the last three to five years, it would not be prudent to base recommendations for 'best buys' solely on this alone. Instead, the updated evidence should be considered in association with that presented in the original *Getting Australians Active* publication, and in light of recommendations from ongoing reviews in the United Kingdom and the United States.

What is clear from all the evidence is that there is no 'magic bullet' approach to getting Australians to be more active. It is evident that all the approaches currently being trialled in Australia and elsewhere have the potential to make small, often short term changes to behaviour. In essence, the 'community wide' and 'environmental and policy' approaches advocated by the US task force are simply a combination of strategies designed to raise awareness (e.g. using media), to improve self

efficacy (e.g. through information and counseling, face-to-face from teachers or health professionals, by telephone or internet, in school classes, work or community groups or individually) and to improve access to places for activity, as well as the availability of physical activity programs. This combination of strategies remains the most strongly recommended approach, notwithstanding the fact that much work is required to test the efficacy of these individual strategies in the Australian context, and to implement and evaluate the impact of concurrent and potentially synergistic strategies in whole communities. Moreover, it is evident that we need more carefully designed and evaluated intervention studies to assess the efficacy of individual strategies in sub-groups of the population, but particularly in those groups who are most likely to be inactive. Current evidence suggests that these include middle-aged adults, older women and Aboriginal and Torres Strait Islanders.

Table 5.1 Summary of recommendations from the US Guide to Preventive Services

Informational Approaches	
• 'Point of decision' prompts to promote stair use	Recommended
• Community wide campaigns	Strongly recommended
• Mass media campaigns	Insufficient evidence
• Class room based health education focused on information provision and skills related to decision making	Insufficient evidence
Behavioural and Social Approaches	
• School based PE	Strongly recommended
• College based health education and PE	Insufficient evidence
• Classroom based health education focused on reducing TV watching and video playing;	Insufficient evidence
• Family based social support	Insufficient evidence
• Social support interventions in community settings	Recommended
• Individually adapted health behavior change programs	Recommended
Environmental and Policy Approaches	
• Creation of or enhance access to places for activity combined with information outreach activities	Strongly recommended

Source: Kahn et al (2002) The effectiveness of interventions to increase physical activity. A systematic review. *American Journal of Preventive Medicine*. 22 (4 Suppl):73–107.

5.3 Summary of Key Points from the Review of National Strategies and Policy Documents in Australia

A review and assessment of existing strategies and frameworks, identified as directly or indirectly relevant to physical activity, and mostly from within the health sector was undertaken to inform the development of a National Strategy for Physical Activity in Australia. The task comprised three components:

- a targeted review of the literature on the development of strategies and frameworks;
- a review of recent strategies and frameworks in Australia; and
- a review of results from a strategic capacity and mapping survey undertaken under the auspices of the National Obesity Taskforce.

More details of the method and findings from this review are presented in Section 3. Key findings and recommendations are summarised below.

Trends in Health Policy

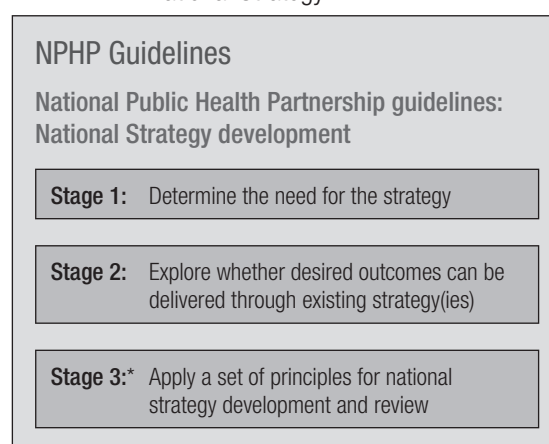
The promotion of physical activity is inherently complex because of the multiplicity of determining factors and because solutions require action beyond the health sector alone. In keeping with overall trends for public health strategies since the mid 1980s, a National Physical Activity Strategy will need to respond to the complexity. In practical terms this means a strategy should:

- be multi-dimensional;
- involve sectors other than health;
- incorporates multiple models;
- include social justice principles/recognises the importance of reducing health disparities;
- recognise the importance of prevention, early intervention and health promotion;
- seek integration and sustainability of its component sub-strategies for greater impact and efficiency; and
- attempt to engage the private sector for the public good

Developing Health Policy

It is strongly recommended that the National Public Health Partnership guidelines for National Strategy Development (National Public Health Partnership, 1999) be applied to the process of developing a National Physical Activity Strategy (see Figure 5.1); and specifically the fifteen principles for the development process as stipulated in Stage 3 (see Figure 5.2).

Figure 5.1 Guidelines for the Development of National Strategy



Source: National Public Health Partnership (1999)

Review of Existing Strategies relevant to Physical Activity

A review of existing health policy in Australia was undertaken and it identified a large number of existing strategies with direct or indirect relevance to physical activity. These included strategies aimed at sub population across the life course, at specific diseases (e.g. diabetes) and in some cases settings (e.g. the SNAP Framework for General Practice). A snapshot of the policy landscape 2003–2004 is shown schematically across the life course in Figure 5.3.

That a range of policies with relevance to physical activity exists is important and should be viewed as a positive. Moreover, it is not surprising that this should be the case, given the mounting and compelling evidence that physical activity is linked to a range of national health priorities including Cardiovascular Health, Cancer, Diabetes, and Injury Prevention. (Bauman et al. 2002) This landscape

provides the opportunity for multiple points of leverage over time on physical activity related activities and it potentially provides a variety of sources of funding and resources. The review therefore notes the considerable scope for synergy with other strategies and frameworks within the health sector. Although it was beyond the scope of that review to consider relevant strategies outside of the health sector, it was noted that the potential for synergy and opportunity exists there also.

Notwithstanding the potential for synergies with health and other strategies, the need for a stand-alone National Physical Activity Strategy is strongly emphasised – not least because of the wide range of health outcomes, other than healthy weight, which are involved. There is, however, a clear need for efficient coordination between other strategies within and outside of the health sector. Acknowledgment of physical activity as a relevant or even essential component within a range of national strategies

is not a guarantee that the necessary allocation of resources will follow; nor does it ensure overall coordination of any investments that do occur. Coordination across the strategies is required so that unhelpful duplication and gaps in essential coverage are avoided. It is strongly recommended that this coordination aspect be articulated as an explicit component of future physical activity policy development. Specific recommendations on opportunities for coordination and linkages between strategies and a future National Physical Activity Strategy in Australia are made in Section 5.5.

Findings from a recent mapping of strategic capacity in Australian Governments Health Sector

In addition to the review of national strategies, the findings from a recent review of strategic capacity and mapping survey undertaken under the auspices of the National Obesity Taskforce were considered. The findings are summarised in detail in Section 3,

Figure 5.2 Principles for Development of National Strategy – Stage 3 of the NPHP Guidelines

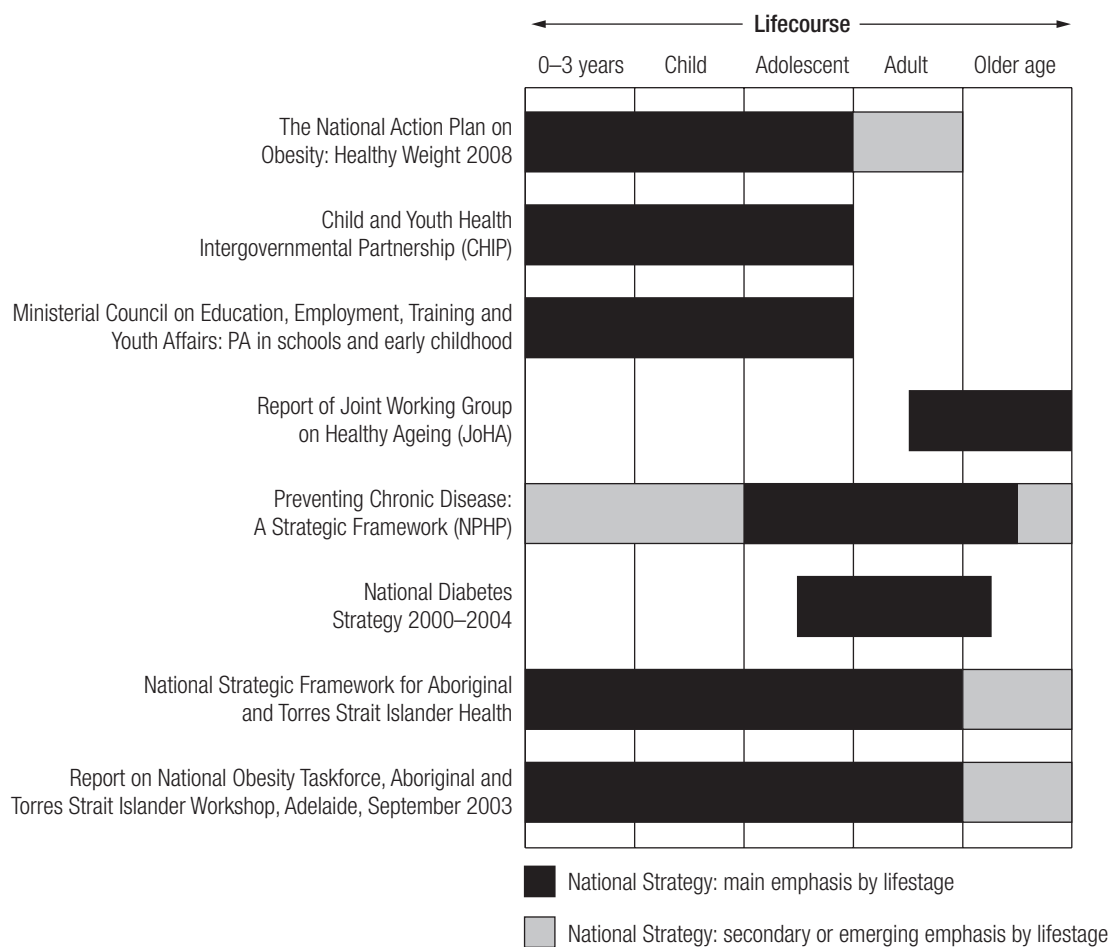
Principles for National Strategy Development

Stage 3: Apply a set of principles for national strategy development and review

- Ensure the key stakeholders are involved from the outset;
- Consolidate the expertise base;
- Establish mechanism to develop strategy;
- Articulate outcomes clearly;
- Address underlying causal factors and promotive factors;
- Ensure appropriateness and relevance;
- Build community capacity;
- Build infrastructure and program maintenance capacity;
- Validate proposed strategies and interventions at the local level;
- Consult across strategies and form coalitions;
- Collaborate with non-health agencies and sectors;
- Adopt an evidence-based approach;
- Contribute to the development of consistent national public health information;
- Ensure evaluation is included from the outset; and
- Use available data optimally

Source: National Public Health Partnership (1999)

Figure 5.3 A Snapshot of the Health-related Policy Landscape in Australia



however in brief, the results reveal that the current capacity and strategic coverage for the promotion of physical activity in Australia is well below optimal levels. It is recommended that ongoing mapping and tracking of capacity, strategic coverage and investment be undertaken as part of a future National Physical Activity Strategy in a manner similar to that proposed by the National Obesity Taskforce. It is possible that this work could be undertaken in collaboration with the Taskforce. Their activities will be undertaken to provide advice on and monitor the implementation of 'Healthy Weight 2008' (Australian Government Department of Health and Ageing 2004).

Options for framing the National Physical Activity Strategy that take account of the literature reviews are set out in Figures 5.4-5.6. In Figure 5.4 the key features or 'scaffolding' of a National Strategy are

identified (these complement the NPHP guidelines on strategy. Figure 5.5 sets out a possible schema for structuring the Action Components of a National Physical Activity Strategy; it has been adapted from the work of the National Obesity Taskforce. Importantly, the schema highlights the multi-dimensional or comprehensive approach required with suggested leadership role delineation for the Federal and State levels.

Figure 5.6 sets out a possible draft framework for a National Physical Activity Strategy in a way that attempts to capture the essential elements from the literature on strategy development. These Figures are not mutually exclusive – taken together they provide resources and tools which may point the way towards the required framework for a National Physical Activity Strategy.

Figure 5.4 Key Components or ‘scaffolding’ identified by the review that might be employed for the development of the National Physical Activity Strategy

“Architecture and Scaffolding” for strategies – the typical components		
<ul style="list-style-type: none"> Principles Outcomes Objectives Roles and responsibility clarification Target groups (including special populations) Stakeholder participation 	<ul style="list-style-type: none"> Partners Collaboration with other national public health strategies (or other sectors) Monitoring and surveillance Evaluation Strategic management 	<ul style="list-style-type: none"> Leadership, training & workforce development Research & development Resource allocation * Service delivery Operational management and coordination

Figure 5.5 Draft Schema for Structuring the Action Components of a National Physical Activity Strategy in Australia

Action Strategies		National Strategies (Australian Government Leadership)			
Settings Strategies (State and Territory Leadership)	Child Care	Community-wide Education	Whole-of-Community Demonstration Areas	Evidence and Performance Monitoring	Coordination and Capacity Building
	Schools – Primary and Secondary				
	Primary Care Services				
	Family and Community Care Services				
	Local Government				
	Neighbourhoods and Community Organisations				
	Sport and Recreation				
	Fitness Industry				
	Media and Marketing				

Particular attention is drawn to ‘Resource Allocation’ in Figure 5.4 given that total current investment across Australia (by all Government Departments of Health) in programs and salaries devoted to Nutrition, Physical Activity and Obesity amounts to an estimated per capita investment of less than AU\$1 (one dollar). It is important to acknowledge

that if the current per capita investment (reported in the AHMAC National Obesity Taskforce Strategic Capacity Survey 2003) is not increased significantly, it is unrealistic to expect any significant developments in strategic capacity or an impact on the problem of inactivity.

5.4 Summary of the Review of International Policy on Physical Activity

This section of the review explored the literature on policy, including policy formation and policy process, to identify a definition and the key characteristics of successful public health policies. In the absence of any alternate, a definition of what constitutes a policy on physical activity was developed. Further, a set of 11 criteria for a successful policy and strategic action plan were created from a synthesis of relevant literature. These criteria were used to review a selected number of countries to assess the focus and content of their existing or emerging policy on physical activity. The methods and findings from this review are presented in more detail in Section 4. Selected summary points are provided below.

Policy is a formal statement that defines priorities for action, goals and strategies, as well as accountabilities of involved actors and allocation of resources. They provide a guide to action to achieve intended goals, initiated by governmental, non governmental or private sector organisations (Milio 2001).

Public policy is policy at any level of government. Traditional areas of public policy are finance, employment, defence, environment, energy and transportation, agriculture and food, leisure, tourism as well as social welfare and health. As all public policies impact, directly or indirectly on health, it is desirable that all public and private policy sectors contribute to the development of healthy public policy. This approach has the greatest potential for increasing the health and well being of the Australian population. It requires, however, that policy makers in all sectors are aware of the health consequences of their decisions as well as of their accountability for health impacts. Particular emphasis is to be given to health impact assessment because it assists policy making by identifying the paths through which health may be benefited or harmed, and by estimating the balance of harm and benefit (Kemmer 2001; WHO 1988).

In response to the epidemiological evidence and potential to modify levels of physical activity, governments as well as non-government

organisations have recognised the need for policy changes to impact on whole population (Brownson et al. 2001). To achieve the goal of population-wide increased levels of physical activity, it is necessary that governments at all levels must play a key role in initiating, coordinating and implementing public policies that promote physical activity enhancing environments accessible by the whole population (Bauman and Bellew 1999).

Definition of a Physical Activity Policy

Taking the characteristics of policy in general and tailoring it to the agenda of physical activity, the following definition has been developed to describe key components of a policy related to physical activity.

Physical activity policy is a formal statement that defines physical activity as a priority area, states specific targets and provides a specific plan or framework for action. It describes the procedures of institutions in the government, non government and private sector to promote physical activity in the population. In addition it should define the accountability of the involved partners.

Criteria for a Successful Policy and Action Plan on Physical Activity

In recent times, specific criteria for successful physical activity policy and action plans (often called 'strategies') have been identified in the literature and at international consensus meetings. (Shepard et al. 2004) These criteria are summarised below:

- **Consultation** with key stakeholders during policy development as well as consideration of the epidemiological evidence on physical activity (e.g. trends, needs assessment)
- Comprehensive policy approach with **multiple agencies**, using multiple strategies (individual-oriented as well as environmental interventions) and targeting different population groups (e.g. children, adolescents, women, older adults, disabled people, indigenous people)
- Working at **different levels** (local, state, national; individual as well as social and physical environmental level)

- Implementation of the policy via **coalitions, alliances and partnerships** (e.g. cross government, non government as well as private sector involvement)
- **Integration** of physical activity policy within other related agendas (e.g. in the field of health, nutrition, transport, environment)
- **Stable support** and resources to implement the policy (e.g. from politicians, governments, organisations)
- **Identity** of the policy by means of a logo, branding or slogan (supported by leading agencies, sports champions and governments, and disseminated within advocacy)
- **Timeframe** of the policy commitment
- **Evaluation** of the policy (systematic approaches supported by budgets)
- **Surveillance** structures in place to monitor the policy
- **National guidelines on physical activity**

Review of International Policy

Using the set of criteria reported above, a review of initiatives in selected countries was undertaken to assess the focus and content of their existing or developing policy on physical activity. More details of this inter-country comparison are provided in Section 4 and additional publications are planned.

In summary, there has been a rapid increase in the number of countries progressing the development of national policy and action on physical activity. This increase may reflect the focus physical activity received as part of World Health Day 2002 and the subsequent development of an annual Move For Health Day agenda and the Move For Health Initiative – a global network for action and the promotion of physical activity.

Most of the countries reviewed are adopting an intersectoral approach as demonstrated by initiatives in Scotland and Switzerland. Consultation and partnership between sectors at a high level of government is an integral part of the process and action plan for implementation. The need for action across the lifespan is acknowledged, and the need for a variety of strategies across different settings.

In most cases the available reports provide only general details of what is planned, the specifics of particular programs (e.g. physical education curriculum content, promotion of stair climbing) are not specified. These specific details may be available in subsidiary planning and implementation documents that are not available via the websites.

The review identified several countries where leadership on physical activity originates from the government department of sport or a similar institution (e.g. New Zealand), from non-government agencies (e.g. Pakistan) as well as 'grass roots' development that has led to a national and regional policy and agenda for physical activity (Agita in Brasil).

The importance of capacity building, through workforce development and at an institutional level is recognised and usually included in the strategic plans. This was true also for the areas of evaluation and monitoring and the need for enhanced investment in research.

Although the recency of development precludes commentary on the effectiveness or relative effectiveness of these policy approaches, some apparent gaps were identified. Specifically, there is little evidence of role clarity between partnerships and an apparent failure to specify achievement criteria, such as clear statements of the completion timelines for proposed actions. Evidence was also limited on the extent to which there was stable financial support, provision for process evaluation and monitoring of the diffusion of physical activity policies and of their long-term effects. It is suggested that these omissions are given careful consideration in the development of a National Physical Activity Strategy in Australia.

Summary

Overall the international comparison revealed a number of similarities in the methods and approaches being adopted around the world in the development of policy on physical activity. This may reflect recent global and regional consultations and collaborations as a consequence of the World Health Organisation's process to develop a Global Strategy on Diet, Physical Activity and Health (WHO 2004). Australia's past efforts on policy for physical activity,

e.g. Active Australia, received recognition worldwide and has been the platform for other countries to design their program and agenda. Although efforts and international collaboration in this area are relatively new, it seems likely that there are lessons to be learned from each country's experience in developing and implementing policy and action plans on physical activity. It is highly recommended that Australia remains engaged in the international and regional agenda and seeks to establish and maintain collaborations.

5.5 Issues and Key Recommendations Towards the Development of a National Physical Activity Strategy

The following issues, recommendations, and specific strategic documents were identified during Phase I review of evidence. It is suggested that these are given careful consideration in the development of a National Physical Activity Strategy (NPAS) and subject to further consideration in the consultation phase of strategy development.

Issues

Public health practice needs to be underpinned by good public health policy (Nutbeam 2003). Current public health policy and strategies have responded to an increasingly sophisticated understanding of health and the complex web of health determinants by:

- becoming multi-dimensional (multiple strategies or 'comprehensive approaches');
- involving sectors other than health;
- incorporating multiple models;
- including social justice principles,
- recognising the importance of prevention, early intervention and health promotion; finding ways to integrate and sustain strategies for greater impact and efficiency, and
- by attempting to engage the private sector for the public good.

Successful policy on physical activity in Australia will require consideration of these trends. It is highly recommended that available literature or best practice guidelines for the development of public health strategies are used. The development of a new National Physical Activity Policy in Australia should consider the process recommended by NPHP in the guidelines for National Strategy Development and specifically the fifteen principles for the development process (NPHP 1999). Taken together with the 11 criteria for successful policy and actions plans on physical activity, they provide a useful outline for the process as well as content.

Key Recommendations

1. Draw on the available literature and best practice guidelines on public health strategy development. For Australia the NPHP Guidelines for National Strategy Development are recommended;
2. Articulate efficient coordination with other key strategies as an explicit component of the National Physical Activity Strategy; there is considerable scope for synergy with other strategies and frameworks within the health sector. To maximise this potential requires emphasis on an efficient coordination of the process – this function needs a corresponding structure and adequate resourcing to be effective;
3. Implement and maintain ongoing mapping and tracking of: 1) capacity (such as surveillance systems, research infrastructure, service infrastructure, workforce development); 2) comprehensiveness of strategic coverage (such as a range of educational, regulatory, environmental and communication strategies across key settings and life stages); and 3) resource allocation (such as investment per capita) as a routine part of National Physical Activity Policy development. In Australia, it is possible that this work could be undertaken by SIGPAH and NPHP in collaboration with the National Obesity Taskforce;

4. Establish Intersectoral Coordination at National Levels – overall the intersectoral nature of physical activity interventions should be considered with a view to achieving strong coordination at National level and preferably with whole of government endorsement at the highest level.
5. Implement systems and processes to enable rapid sharing of knowledge between Intersectoral coalitions and groups within and between nations. In Australia, several State-based Intersectoral Task Force exist; they comprise different membership and function in different ways; there is a clear need for mechanisms to integrate both state and federal action as well as sharing of information;
6. The strategies, outcomes and action examples proposed under the Obesity Policy – Healthy Weight 2008 (HW2008) have direct relevance for a National Physical Activity Strategy and in some instances may usefully feature in both HW2008 and a National Physical Activity Policy with appropriate cross-references. For implementation, SIGPAH needs to consider the value of a strategic focus on young people (0–18) and families as opposed to middle (e.g. 35–55) or later years (e.g. 55+) which are arguably more in line with chronic disease prevention or healthy ageing foci. Notwithstanding the potential for synergies, *the need for a stand-alone National Physical Activity Strategy is strongly emphasised* – not least because of the wide range of health outcomes other than healthy weight that are involved.
7. Healthy Ageing: the Joint Working Group on Healthy Ageing has stated an expectation that older persons will be included as a priority population within the National Physical Activity Action Plan when developed; this would be consistent with Australia's National Strategy for an Ageing Australia. Strategies designed to create environments supportive of physical activity will also benefit older people and may particularly be useful with respect to opportunities for walking safely. There is also potential synergy with Injurious Falls Prevention policy such as the initiatives stipulated by Australia's Strategic Injury Prevention Partnership.
8. Primary Health Care: the opportunity to reinforce and coordinate with the agenda around primary health care and general practice and selected behavioural risk factors should be carefully considered. In Australia the NPHP Strategic Framework for Chronic Disease Prevention and the 'SNAP' initiatives are pertinent to Physical Activity policy;
9. Diabetes Strategy/ Diabetes Prevention Program: cross-referencing of the National Physical Activity Strategy with these initiatives is advisable. SIGPAH may need to consider whether existing mechanisms are sufficient to ensure ongoing coordination;
10. Child and Youth Health: physical activity policy should include strong coordination of initiatives in child and youth health given the increasing focus on the early years of life and the typical abundance of policies in this area. In Australia the advent of the Child And Youth Health Intergovernmental Partnership (CHIP) may facilitate this. Existing mechanisms should be reviewed in order to assess if they are sufficient to ensure ongoing coordination and to take advantage of CHIP.
11. Aboriginal and Torres Strait Islander people: The National Physical Activity Strategy needs to address the needs of Aboriginal and Torres Strait Islander peoples – this might arguably be conceived as a separate strategy (such as NATSINSAP) and might seek compliance with the NPHP Guidelines, the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003) and the Adelaide Report (2003); and
12. Acknowledge the needs of people with disabilities and of culturally and linguistically diverse populations in the strategy.

5.6 A Draft Framework for a National Physical Activity Strategy

To facilitate future discussions a draft framework for a National Physical Activity Strategy is shown in Figure 5.6.

Figure 5.6 A Draft Framework for a National Physical Activity Strategy

A National Physical Activity Strategy (2004–2010)¹⁶

Strategic Intent

An example might be: ‘Assist Australians to enjoy the highest levels of good health in the world by promoting increased participation in physical activity’

Goals

Examples might be:

- Achieve better health, social and economic outcomes through actions which first stop and then reverse the increasing rates of sedentary behaviour
- Increase the proportion of Australians who participate in adequate levels of physical activity to maintain or enhance their health
- Ensure children, young people, families and communities have the requisite knowledge, skills, opportunities and resources for a physically active lifestyle
- Address the broader social and environmental determinants of sedentary and active lifestyles
- Focus action on giving people the best possible chance to maintain or enhance health through a physically active lifestyle as part of their routine, everyday contacts and settings

The Need for Action (Rationale)

This section might usefully outline health gains available, widespread impacts socially and economically, greatest gains come from moving out of the most sedentary category, the need for a population wide effort, the evidence is accumulating but is already sufficient to prompt us to action, a decision to take no action is a decision to allow levels of sedentariness to worsen and would be unethical.

Guiding Principles

Examples might include:

Actions should:

- Concentrate on solutions not problems – with a bias for action on health promoting environments.
- Be long-term and sustainable, recognising that behaviour change is complex, difficult and takes time.
- Help those most in need and close the health gap between different population groups as a result of geography, ethnicity, and socio-economic status.
- Promote the positive benefits of active living.
- Empower and assist all groups to take action according to their own opportunities and responsibilities.

Target groups (including special populations)

to be specified – with rationale

¹⁶ Suggested model based on ‘Healthy Weight 2008 – Shaping Australia’s Future’ released by the National Obesity Taskforce

Settings Strategies (Emphasis: Leadership by State and Territory Governments)

see possible schema in Figure 5.5

National Strategies (Emphasis: Leadership by Australian Government)

see possible schema in Figure 5.5

Coordination and Capacity Building

see possible schema in Figure 5.5

(includes collaboration/coordination mechanisms with other national public health strategies (and sectors), strategic management, operational management coordination, infrastructure support, resource allocation protocols, service delivery standards and guidelines, community and stakeholder participation, leadership, training and workforce development)

Evidence and Performance Monitoring

see possible schema in Figure 5.5

(includes monitoring and surveillance systems, measurement development, analysis, evaluation, policy and action research to inform planning and management, and enhance accountability)

Whole of Community' Demonstration Areas

see possible schema in Figure 5.5

(includes integrated actions from all the Settings implemented in discrete population areas as potential models for wider long term implementation in other communities and to enhance community ownership and capacity for sustained action)

Community-wide Education

see possible schema in Figure 5.5

(includes planned mass media communication and education, overall marketing strategy for the National PA Strategy, public relations, use of 'new' technologies; leadership by Australian Government but strong engagement required by all States and Territories for successful and efficient outcomes)

Roles and responsibility clarification

see possible schema in Figure 5.5

Emphasis of National Strategies is on Australian Government leadership – Emphasis of Settings Strategies is on State and Territory Government leadership

Resource Allocation

Acknowledge that if the current per capita investment (reported in the AHMAC National Obesity Taskforce Strategic Capacity Survey 2003) is not increased significantly, developments in strategic capacity or an impact on the problem of inactivity are unlikely.

Partners

e.g. Emphasis on intersectoral nature of physical activity policy, growth in State-based task forces, need for intersectoral mechanisms at Federal level, need for mechanisms to share knowledge and innovation across the State based task forces in systematic way

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